Colorado Department of Labor and Employment
Unemployment Insurance Operations
P.O. Box 400, Denver, CO 80201-0400
303-318-9000 (Denver-metro area) or 1-800-388-5515 (outside Denver-metro area)

Print or type complete name and address below

Date
Social Security Number (last four digits) XXX-XX-
Due Date

REPORT ON TREATMENT PROGRAM

By signing your name in **Section 1**, you authorize your treatment program to provide information to Unemployment Insurance (UI) Operations. **Section 2** is to be completed by an authorized representative of your treatment program. Complete and sign **Section 3** only **after** the treatment-program representative has completed **Section 2**. By signing your name in this section, you are confirming that you understand the information provided by the treatment-program representative. You are responsible for returning the form.

Section 1. Consent to Release Information

I consent to release the requested information for the purposes of processing my claim for UI benefits with the understanding that the information is for use in determining my eligibility and entitlement for UI benefits in accordance with the Colorado Employment Security Act 8-73-108 (4)(b).	
Claimant Signature	Date

Section 2. (To be completed by treatment-program representative only)

The person named above has applied for UI benefits. Obtaining the information requested below will help UI Operations make a determination of eligibility and entitlement. Any alteration must be initialed. Your cooperation in providing this information is appreciated. **The completed form must be returned to UI Operations by the person named above**.			
Name and Address of Treatment Program or Facility	Type of Program ☐ Private facility ☐ Public facility ☐ Alcoholics Anonymous or other 12-step program		
Nature of Treatment ☐ Residential ☐ Inpatient ☐ Outpatient ☐ Confined ☐ Combination (Please explain) _____	Treatment Schedule		
	Start Date	End Date	Days and Hours
Additional Comments			
Name of Authorized Representative		Telephone Number	
Authorized-Representative Signature		Date	

Section 3.

I have read and understand the above statement provided by the treatment-program representative.	
Comments	
Claimant Signature	Date